Cambridgeshire Community Services NHS Trust

# Infection Prevention and Control Board Assurance Framework - September 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them

| | Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
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| | Systems and processes are in place to ensure that: | | | |
| 1.1 | A respiratory plan incorporating respiratory seasonal viruses that includes<br>point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services<br>▪ to enable appropriate segregation of cases depending on the pathogen.<br>▪ a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms / units as part of the Trusts winter plan. | N/A refers to inpatient care.<br><br>Monitoring of positive staff is initially managed by service leads, with the support of IPaC. | No Gaps identified 29/09/2022 | |
| 1.2 | Segregation of patients depending on the infectious agent taking into account those most vulnerable to infection eg clinically immunocompromised<br>– a surge/escalation plan to manage increasing patient/staff infections<br>– a multidisciplinary team approach is adopted with hospital leadership, operational teams, estates and facilities, IPC teams and clinical and non-clinical staff to assess and plan for | iCaSH triage potential Monkeypox cases and segregate to prevent immunosuppressed patient contact.<br>BCP and services risk assessments in place.<br>N/A inpatient. Dedicated clinical rooms for | No gaps identified 29/09/2022 | |

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| | creation of adequate isolation rooms/cohort units as part of the plan.<br>Organisational /employers risk assessments in the context of managing infectious agents are:<br>– based on the measures as prioritised in the hierarchy of controls<br>– applied in order and include elimination; substitution, engineering, administration and PPE/RPE<br>– communicated to staff<br>– further reassessed where there is a change or new risk identified eg. changes to local prevalence. | Monkeypox assessment identified in all iCaSH.<br>Building risk assessments, discussed at weekly IPaC and discussed at IMT meetings. | | |
| 1.3 | The completion of risk assessments have been approved through local governance procedures, for example integrated care systems. | Compliant | No gaps identified 29/09/2022 | |
| 1.4 | Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents. | Compliant | No gaps identified 29/09/2022 | |
| 1.5 | Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons. | N/A refers to inpatients | | |
| 1.6 | Resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors).<br>The application of IPC practices within the NIPCM is monitored e.g. 10 elements of SICPs. | Monitored through environmental audits, staff self-assessments, CIAs, Occupational Health and access to IPaC. | No gaps identified 29/09/2022 | |
| 1.7 | The IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at trust board level. | Compliant | No gaps identified 29/09/2022 | |
| 1.8 | The trust board has oversight of incidents/outbreaks and associated action plans. | Compliant | No gaps identified 29/09/2022 | |
| 1.9 | The trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required. | Compliant | No gaps identified 29/09/2022 | |

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

| | Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
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| | Systems and processes are in place to ensure that: | | | |
| 2.1 | The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. | Compliant. Rolled out April 2022. Full implementation October 2022 to be monitored at IPaC committee as a standing item. | No gaps identified 29/09/2022 | |
| 2.2 | The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room. | Compliant | No gaps identified 29/09/2022 | |
| 2.3 | Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment. | Compliant<br>Evidence on Audim. | No gaps identified 29/09/2022 | |
| 2.4 | Enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (section 2.3) or local policy and staff are appropriately trained. | Compliant. Increased frequency requested where appropriate as agreed with IPaC. | No gaps identified 29/09/2022 | |
| 2.5 | Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products. | Compliance<br>Disinfectants received as part of the national delivery system. | No gaps identified 29/09/2022 | |
| 2.6 | For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in:<br>patient isolation rooms<br>– cohort areas<br>– donning and doffing areas – if applicable<br>– 'frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails | N/A refers to inpatients<br>Compliant for donning and doffing in Dental and iCaSH | No gaps identified 29/09/2022 | |

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| | – where there may be higher environmental contamination rates, including: toilets/commodes particularly if patients have diarrhoea and/or vomiting. | | | |
| 2.7 | The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness | Posters and pledge signed off by CEO. | National template poster has been amended to reflect the Trust. The distribution of the revised posters will be disseminated by the Trust's Quality Team. The revised posters will be distributed by the end of November. Distribution of the posters will be monitored by the IPaC team. | Posters sent out to IPaC Link Champions electronically prior to the distribution of hard copies. |
| 2.8 | A terminal clean of inpatient rooms is carried out:<br>– when the patient is no longer considered infectious<br>– when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens)<br>– following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). | No inpatients service. Toilets and high touch areas cleaned twice a day.<br>Deep cleans undertaken for outbreaks and terminal cleans carried out following discharge of suspected Monkeypox case from iCaSH clinic. | No gaps identified 29/09/2022 | |
| 2.9 | Reusable non-invasive care equipment is decontaminated:<br>– between each use<br>– after blood and/or body fluid contamination | Compliant | No gaps identified 29/09/2022 | |

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|  | – at regular predefined intervals as part of an equipment cleaning protocol<br>before inspection, servicing, or repair equipment. |  |  |  |
| 2.10 | Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment. | Compliant<br>Snapshot audits. | No gaps identified<br>29/09/2022 |  |
| 2.11 | Ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes. | Note evidence is specifically in relation to air changes. HTM03-01 was revised in Jun 2021, systems that were designed and the installed after this date have been designed (with derogations). | Any systems prior to this date will have been designed, commissioned, installed, and maintained to the pre HTM03-01 version. And may simply be the prevailing building regulations or we may not be able to install ventilations systems because of planning regulations e.g., listed buildings. | New designs will incorporate current standards e.g. NCH refurbishment, PoW, CDC (diagnostic).<br><br>Portable air scrubbers are used in clinical areas where additional mechanical ventilation is required.<br><br>Development of a ventilation strategy |
| 2.12 | Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible. | Trust ventilation lead in discussion with Estates and IPaC. Lead reports to IPaC Committee.<br><br>Volumetric analysis and works requests and ensuing reports for specialist ventilation | The initial ventilation strategy, policy and procedures have been reviewed at the IPaC huddle. Feedback given to the team, | The Trust purchased portable air scrubbers available which are being used in clinical settings. |

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|  |  | assessment – available on request by team. Assessments are carried out / reviewed by the Trust's ventilation lead and actions taken where required. Assessments are presented and discussed at the Trust's IPaCC. The ventilation group is now incorporated within the IPaCC ToR. | Update to be given at the next IPaC huddle on 14.11.22. |  |
| 2.13 | Where possible air is diluted by natural ventilation by opening windows and doors where appropriate. | Comms messages to all staff, team meetings and IPaC link champions, reports and minutes to IPaCC committee. | No gaps identified 29/09/2022 |  |

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

| | Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
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| | Systems and processes are in place to ensure that: | | | |
| 3.1 | Arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated. | Anti-microbial usage is currently audited and reported every 6 months. Data is presented to the MSGG and IPaC Committee. | A formal lead has been identified (Chief Nurse).<br><br>Lead to review the 'ask' and identify next steps. | Arrangements for antimicrobial reporting and governance are already in place. |
| 3.2 | NICE Guideline NG15 is implemented – antimicrobial stewardship: systems and processes for effective antimicrobial medicine use. | Compliant<br>Prescribing in iCaSH is in accordance with BASHH/ BHIVA guidelines and local antimicrobial formularies, confirmed by 6-monthly audits.<br>Prescribing in dentistry is in accordance with GDC guidance (Trust dental guidelines), confirmed by 6-monthly audits.<br>Prescribing of antibiotics in other services is confirmed by 6-monthly audits and review of epact data.<br>The Trust involves a consultant microbiologist in guideline/ | No gaps identified 29/09/2022 | |

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| | | PGD/Formulary development.<br>The regular audits confirm indication, dose, duration of treatment, as well as allergy checks.<br>The iCaSH service has additional standards for the use of sensitivity cultures for gonorrhoea.<br>The results of the audits are shared with the Medicines Safety Group and the IPaC Committee, and with the services concerned.<br>The pharmacy and Infection prevention and control teams work closely together.<br>New antimicrobials would only be introduced in accordance with BASHH/ BHIVA guidelines and local antimicrobial formularies following peer discussion within the Trust and involving relevant consultant microbiologists. | | |
| 3.3 | The use of antimicrobials is managed and monitored:<br>– to optimise patient outcomes<br>– to minimise inappropriate prescribing<br>– to ensure the principles of Start Smart, Then Focus are followed. | Reviewed at IPaC committee as separate action planning.<br>The antimicrobial audit matches the antibiotic to | No gaps identified 29/09/2022 | |

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| | | the indication, and the auditor checks that it is in accordance with the guidelines. | | |
| 3.4 | Contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including:<br>– total antimicrobial prescribing<br>– broad-spectrum prescribing<br>– intravenous route prescribing. | Prescribing of antibiotics known to be associated with the emergence of other pathogens (e.g., C diff) is queried and addressed with the prescriber as part of the electronic prescribing and cost (epact) review.<br>Anti-microbial usage is monitored via the Epact data by the Pharmacy Team. Antibiotic audits are in place currently every 6 months.<br>Antimicrobial data is discussed and presented at the Trust's Medicine Management Group and IPaCC.<br>The Trust publishes its own Dental and iCaSH formularies based on national and local microbial advice from the Trust's IPaC Consultant. | As 3.1 | As 3.1 |
| 3.5 | Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors). | Regular audits of antibiotic use take place, as described above. | No gaps identified 29/09/2022 | |

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.

| | Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
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| | Systems and processes are in place to ensure that: | | | |
| 4.1 | IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use. | Compliant.<br>Posters. | No gaps identified 29/09/2022 | |
| 4.2 | Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors. | N/A refers to inpatients. | | |
| 4.3 | National principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. National guidance on visiting patients in a care setting is implemented. | N/A refers to inpatients. | | |
| 4.4 | Patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice. | Compliant<br>All services. | No gaps identified 29/09/2022 | |
| 4.5 | Restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives. | N/A refers to inpatients. | | |
| 4.6 | There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment. | N/A refers to inpatients. | | |
| 4.7 | If visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE. | N/A refers to inpatients. | | |

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| 4.8 | Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting. | N/A refers to inpatients. | | |
| 4.9 | Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment eg carer/parent/guardian. Implementation of the supporting excellence in infection prevention and control behaviours Implementation toolkit has been adopted where required. | Compliant<br>Although if accompanying Dental patients, carer/guardian masked and placed outside of AGP zone. | No gaps identified 29/09/2022 | |

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

| | Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
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| | Systems and processes are in place to ensure that: | | | |
| 5.1 | All patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients). | Compliant<br>Triage questions. | No gaps identified 29/09/2022 | |
| 5.2 | Signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM). | Compliant | No gaps identified 29/09/2022 | |
| 5.3 | The infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement. | Compliant.<br>Transfer from community teams to other healthcare providers. | No gaps identified 29/09/2022 | |
| 5.4 | Triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated. | Compliant<br>No inpatients, however, triage questioning in all clinical services. | No gaps identified 29/09/2022 | |
| 5.5 | Patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (type II or type IIR) if this can be tolerated. | N/A refers to inpatients. | | |
| 5.6 | Patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite). | N/A refers to inpatients. | | |

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| 5.7 | Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available. | N/A refers to inpatients. | | |
| 5.8 | Patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg priority for single room protective isolation. | N/A refers to inpatients. | | |
| 5.9 | If a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. | Compliant | No gaps identified 29/09/2022 | |
| 5.10 | The use of facemasks/face coverings should be determined following a local risk assessment. | Compliant – use of local surveillance to inform mask wearing protocol | No gaps identified 29/09/2022 | |
| 5.11 | Patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy. | Compliant | No gaps identified 29/09/2022 | |
| 5.12 | Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection | Compliant | No gaps identified 29/09/2022 | |
| 5.13 | Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures. | Compliant | No gaps identified 29/09/2022 | |

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

| | Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
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| | Systems and processes are in place to ensure that: | | | |
| 6.1 | IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties. | Patients and visitors are reminded of IPaC best practice through posters, letters (PPE) etc.<br>Online training for staff as well as virtual or face to face where deemed appropriate. | No gaps identified 29/09/2022 | |
| 6.2 | training in IPC measures is provided to all staff, including: the correct use of PPE. | All clinical staff undertake IPC training which incorporates standard precautions. This is recorded on the Electronic Staff Record and reported on the Quality Dashboard. This is monitored for each service via the relevant clinical Operational Board.<br>Enhanced training on additional precautions including donning and doffing is discussed / demonstrated during respirator fit testing for staff undertaking Aerosol Generating Procedures. | No gaps identified 29/09/2022 | |

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| | | IPaC Manual and national Covid19 guidelines available to staff. | | |
| 6.3 | All staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM). | Compliant<br>As above<br>UV hand hygiene staff assessments. | No gaps identified 29/09/2022 | |
| 6.4 | Adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk. | Compliant<br>Clinical Intervention Audits and Datix. | No gaps identified 29/09/2022 | |
| 6.5 | Gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's. | As above | No gaps identified 29/09/2022 | |
| 6.6 | Hand hygiene is performed:<br>– before touching a patient<br>– before clean or aseptic procedures<br>– after body fluid exposure risk<br>– after touching a patient<br>– after touching a patient's immediate surroundings. | Compliant<br>Guidance available for all staff, Link Champions trained in 5 Moments of Hand Hygiene. | No gaps identified 29/09/2022 | |
| 6.7 | The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM). | Compliant | No gaps identified 29/09/2022 | |
| 6.8 | Staff understand the requirements for uniform laundering where this is not provided for onsite. | Guidelines communicated through regular comms messages, team meetings and via the Trust's IPaC guidelines. | No gaps identified 29/09/2022 | |

7. Provide or secure adequate isolation facilities

| | Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
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| | Systems and processes are in place to ensure that: | | | |
| 7.1 | That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. | N/A refers to inpatients | No gaps identified 29/09/2022 | |
| 7.2 | Patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM. | Compliant | No gaps identified 29/09/2022 | |
| 7.3 | Patients are appropriately placed ie infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent. | N/A refers to inpatients, however, segregation of potential Monkeypox infected patients in iCaSH – no cohorting. | No gaps identified 29/09/2022 | |
| 7.4 | Standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings. | Compliant | No gaps identified 29/09/2022 | |
| 7.5 | Transmission based precautions (TBP) may be required when caring for patients with known/suspected infection or colonization. | Compliant | No gaps identified 29/09/2022 | |

8. Secure adequate access to laboratory support as appropriate

| | Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
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| | Systems and processes are in place to ensure that: | | | |
| 8.1 | Laboratory testing for infectious illnesses is undertaken by competent and trained individuals. | All UKHSA Laboratories in the region are currently working towards re-accreditation by UKAS. | Assessments were initially put on hold due to the Covid pandemic. UKHSA (located at CUHFT) laboratory services review was postponed by UKAS due to unprecedented work demands. Initial assessments complete, additional supporting evidence submitted to UKAS in September. Awaiting follow up visit. Awaiting assurance from other laboratories. | If there were concerns raised with any laboratories, this would be communicated to the Trust with the relevant alternative pathway in place. |

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| 8.2 | Patient testing for infectious agents is undertaken promptly and in line with national guidance. | Compliant | No gaps identified 29/09/2022 | |
| 8.3 | Staff testing protocols are in place for the required health checks, immunisations and clearance. | Monitored through OH. | No gaps identified 29/09/2022 | |
| 8.4 | There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. | Compliant | No gaps identified 29/09/2022 | |
| 8.5 | Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise. COVID-19 specific | N/A refers to inpatients | No gaps identified 29/09/2022 | |
| 8.6 | Patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. | N/A refers to inpatients | No gaps identified 29/09/2022 | |
| 8.7 | Coronavirus (COVID-19) testing for adult social care services. For testing protocols please refer to: COVID-19: testing during periods of low prevalence | N/A refers to inpatients | No gaps identified 29/09/2022 | |

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

| | Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
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| | Systems and processes are in place to ensure that: | | | |
| 9.1 | Resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors). | Compliant<br>IPaC overarching policy, guidelines, AMS policy, Clinical Intervention audits, cleaning standards, Datix. | No gaps identified 29/09/2022 | |
| 9.2 | Staff are supported in adhering to all IPC and AMS policies. | Compliant<br>Supported by Link Champions, Leadership, MSGG steering group. | No gaps identified 29/09/2022 | |
| 9.3 | Policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak. | Compliant<br>Document library | No gaps identified 29/09/2022 | |
| 9.4 | All clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM. | Compliant<br>Note: linen/laundry N/A as refers to inpatients | No gaps identified 29/09/2022 | |
| 9.5 | PPE stock is appropriately stored and accessible to staff when required as per NIPCM. | Compliant<br>PPE team deliver PPE stock as per teams request. PPE Trust Leads in place to support the national PPE agenda. | No gaps identified 29/09/2022 | |

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

| | Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
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| | Systems and processes are in place to ensure that: | | | |
| 10.1 | Staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy. | All staff have access to OH services. | No gaps identified 29/09/2022 | |
| 10.2 | Bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff. | Compliant | No gaps identified 29/09/2022 | |
| 10.3 | Staff understand and are adequately trained in safe systems of working commensurate with their duties. | Compliant | No gaps identified 29/09/2022 | |
| 10.4 | A fit testing programme is in place for those who may need to wear respiratory protection. | Staff undertaking AGP's or who are assessing for Monkeypox, are fit tested. Local database currently held, documented on ESR as per national requirements. | No gaps identified 29/09/2022 | |
| 10.5 | Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:<br>– lead on the implementation of systems to monitor for illness and absence<br>– facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice<br>– lead on the implementation of systems to monitor staff illness, absence and vaccination<br>– encourage staff vaccine uptake. | Compliant<br>OH services in place. | No gaps identified 29/09/2022 | |
| 10.6 | Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to | Compliant | No gaps identified | |

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| | follow the infection control precautions, including PPE, as outlined in NIPCM. | | 29/09/2022 | |
| 10.7 | A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19<br>– a discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups<br>– that advice is available to all health and social care staff, including specific advice to those at risk from complications<br>– bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff<br>– a risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. | Risk assessments in place for staff and their line manager to complete and record in their personal file. | No gaps identified 29/09/2022 | |
| 10.8 | Testing policies are in place locally as advised by occupational health/public health. NHS staff should follow current guidance for testing protocols. | Compliant<br>Within OH contract, iCaSH SOP re sharp's injuries / BBV's, Mass vaccination plan including seasonal influenza, Covid19 vaccination programme. | No gaps identified 29/09/2022 | |
| 10.9 | Staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a record of this training is maintained by the staff member and held centrally/ESR records. | Compliant | No gaps identified 29/09/2022 | |
| 10.10 | Staff who carry out fit test training are trained and competent to do so. | Fit testing of staff was undertaken by IPaC Lead at the beginning of the Covid pandemic as the only trained member of staff identified to train other staff, who | No national guidance produced to ensure trained fit testers receive regular refresher | Discussed at the IPaCC in October 2022 and it was agreed to pursue an external organisation to facilitate refresher training. |

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|  |  | subsequently supported a fit testing of staff.<br>An additional 2 members of staff (dental) completed a fit test programme to become competent assessors and trainers. The rest of the IPaC nursing team was also trained previously. | training as best practice. |  |
| 10.11 | Fit testing is repeated each time a different FFP3 model is used. | As per FFP3 register | No gaps identified 29/09/2022 |  |
| 10.12 | All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks. | Partial compliance | Use of hoods and reusable FFP3. |  |
| 10.13 | Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood. | Compliant<br>Information stored centrally and ESR. | No gaps identified 29/09/2022 |  |
| 10.14 | That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions. | Compliant | No gaps identified 29/09/2022 |  |
| 10.15 | Members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. | Compliant | No gaps identified 29/09/2022 |  |
| 10.16 | A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. | Information held with line manager and HR. | No gaps identified 29/09/2022 |  |
| 10.17 | Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety | Compliant. | No gaps identified |  |

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| | and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. | Compliance with agreed IPaC AGP procedures for services. Data discussed as part of IPaC report and fed back to IMT. Completed building risk assessments reviewed by IPaC and Estates and discussed weekly at IMT. | 29/09/2022 | |
| 10.18 | Staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work. | Compliant | No gaps identified 29/09/2022 | |